Screening Questionnaire for Injectable Influenza Vaccination 2014

For office use only
Employee_____
Paid _____
Date_____
Initial_____

Information about person to receive vaccine. (Please Print)				
Name: Last	**First**	**Middle Initial**	**Birthdate**	**Age**
Address: Street	**City**	**County**	**State**	**Zip**

	Yes	No	Don't Know
1. Is the person to be vaccinated sick today?	☐	☐	☐
2. Does the person to be vaccinated have an allergy to eggs or to a component of the vaccine?	☐	☐	☐
3. Has the person to be vaccinated ever had Guillain-Barré syndrome?	☐	☐	☐
4. Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past?	☐	☐	☐

I have read or have had explained to me the information about influenza and influenza vaccine. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of influenza vaccine and ask that the vaccine be given to me or the person named below from whom I am authorized to make this request.

Form completed by:_____ **Date**:_____

Form reviewed by:_____ **Date**:_____

++++++++++++++++++++ **For Health Department Use** ++++++++++++++++++++

Date Vaccine Administered_____ - -2014_____

Vaccine Manufacturer:_____Fluarix - Quad_____

Vaccine Lot Number: _____2A2KX_____

Site of Injection:_____LD RD_____

Signature of Vaccine Administrator:_____